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NEW PERSPECTIVES: PART II

Demystifying Geriatrics: Patient Stratification

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In my years of geriatric practice at Stanford, I have worked with four distinct groups of geriatric patients. This stratification is based on variations in age, health conditions, functional status, and socioeconomic status/support system and follows a model that is routinely followed by oncologists.[1] Note that within each age group there is significant diversity, more or less, influenced by the same factors listed above. Each stratum requires a specific strategy and demands a specific level of effort. Naturally, some are more taxing than others.

1. *The Super Healthy*. This is a geriatric patient population who, much like its younger counterparts, has no chronic illnesses but occasionally gets the cold and upset stomach that almost everybody suffers from every now and then. These patients are lucky enough to have the benefits of both good genes[1] and a healthy lifestyle.
2. *The Independent*. These are patients with one to three chronic yet very well-managed diseases. They may live at home or in independent-living senior care facilities.
3. *The Middle-ground Occupier*. These are patients who have some significant ailments and need to be assisted routinely. These patients can become frail if not managed properly. However, if managed well, they can bounce back to become independent again. They may live with their families or in assisted-living senior facilities.
4. *The Frail*. These are patients who exhibit noticeable decline in their health status without being able to reverse that decline despite best efforts. They may live with their families or in assisted-living senior facilities.

It is the last two groups whose reserve is generally very limited. This condition is referred to in geriatric textbooks as homeostenosis.[2]

This same mix exists everywhere in the United States, but the proportions of each group might change from one geographic area to another. These changes are generally influenced by dietary habits, lifestyle, climate, socioeconomic status, and the ethnic composition of each area.[3]

It is my intention to briefly explain my approach to each of these groups, including the type and amount of work they require, but before I begin, I want to emphasize the importance of looking at the big picture and promoting a family-centered approach.

The Super Healthy require minimal effort that is different in nature from the others. Because they are in good health, some of them do not seem to be compelled to follow up with their doctors for annual checkups or even listen to their doctors when their doctors suggest some precautionary measures. Examples include getting flu shots and taking supplemental vitamins or prophylactic aspirin. For this group, I recommend a checkup once a year.

The Independents are generally a lot more compliant but still require more effort than the Super Healthy. I ask for a visit every three to six months, check labs, review medications, and try to keep them at the same level of health or improve their health by adjusting their medications or recommending lifestyle changes. These efforts do not always work because either patients do not comply fully with the change in lifestyle or their diseases require taking medications on a routine basis, even after a lifestyle change.

It is the Super Healthy and the Independent groups that should be offered a full range of preventive services including screening colonoscopies and mammograms, as the benefits of early detection significantly outweigh the potential unwanted side effects of the screening tests.[4]

The Middle-ground Occupiers, by far, consume the most amount of time, and they are the ones who literally keep me up at night. At the same time, they have the potential to offer the most satisfaction. With intensive effort, some of these patients bounce back to join the Independent group. In some cases, this effort may last as long as a year. Once they bounce back, some of them feel that they have found their life again, and as a practitioner it is hard to have a feeling more gratifying than that. On the negative side, some of them start declining despite best efforts. This can be hard to take as a practitioner, as it feels like the practitioner has failed!

These patients account for most of the calls I receive at night, but by setting some protocols and providing the right training to the nursing staff or caregivers, these calls can be kept to a minimum.

These are the patients that need to be rehabilitated aggressively and periodically to maintain their functional status and independence as much as possible.

The Frail are the patients who either have terminal diseases like metastatic cancer or multi-system disorders with no chance of full recovery. Their code status can range from full code to DNR with comfort care only. Some of these patients have reduced cognitive functions like advanced Alzheimer's while others are fully alert and aware of their conditions. For them, the best thing a practitioner can offer is comfort measures, making

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sure that their living environment is safe and that they have an adequate support system. A careful medications review, discontinuing all the ones that are not essential, is, critical in improving their quality of life.

Patients with declining cognitive function represent a specific subgroup that can put the practitioner's conscience in a dilemma, as the practitioner is sometimes forced to limit their privileges. For me, one of the lowest points in a work week is when I have to report a patient to the Department of Motor Vehicles to revoke that patient's driver's license, even though I know this will severely curb his/her mobility. Some of these patients I have known for years and observed their decline without being able to reverse the process.

Geriatric practitioners tend to see their patients throughout the continuum of health care (i.e. hospital, clinic, skilled nursing, and home). Successful practitioners should strive to keep their patients out of hospitals as much as possible.

To summarize my approach to dealing with patient care, a successful geriatric practitioner is someone who follows these golden rules:

1. No matter what stratum patients are in, make sure they are seen for routine visits. This ensures that health is maintained and avoids unnecessary urgent follow-up visits.
2. Remember to triage problems at the beginning of a visit. For patients with complex medical and psychosocial issues, schedule them for return visits within a short period of time in order to address their issues in greater detail over multiple visits.
3. Always review medications and discontinue the non-essential ones. Replace risky medications with safer ones whenever feasible.
4. With any new medication, follow the common wisdom of "start low and go slow."
5. When introducing a new medication, it is highly probable that any new symptom is a medication side effect. As a general rule, a new symptom is a medication side effect until proven otherwise.[5]
6. Avoid a cascade of prescriptions (i.e. do not prescribe a new medication to treat the side effect of another one). Sometimes, however, this may not be so easy to avoid. An example is treating constipation that results from narcotics with a laxative.
7. Involve patients in the decision-making process and set clear expectations. When speaking, always try to address your patient and maintain good eye contact. That will send the clear message that you care!
8. When patients are incapacitated or patients want their loved ones to be involved in decision making, make sure that only one person is chosen as the decision maker.
9. Be empathic and listen! Even when you cannot offer a cure, you can offer a listening ear. I cannot emphasize how many times I have been told "if only my doctor listened to me" or "thank you for listening." Simply validating concerns, even though you may not have a solution, can have far-reaching effects on patients.
10. Utilize community resources to help support your patients. Take advantage of rehab programs and encourage patients to explore options with you. A common scenario is caring for a patient with Alzheimer's disease at home—adult daycare or respite programs can be of great benefit in those cases.

In conclusion, geriatric patients can be complex, but when breaking their complex issues into small building blocks and dealing with them in a scientific manner, the inherent difficulties in managing their problems will dramatically decrease. Geriatrics can be a very gratifying practice both professionally and emotionally if approached with the right attitude and knowledge of available tools and resources.

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